

## Division of Health Care Facilities

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  TN3311	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED  11/15/2012
NAME OF PROVIDER OR SUPPLIER  NHC HEALTHCARE, CHATTANOOGA			STREET ADDRESS, CITY, STATE, ZIP CODE 2700 PARKWOOD AVE CHATTANOOGA, TN 37404		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE	
N 000	Initial Comments  During the annual Licensure survey conducted on November 12-15, 2012, no deficiencies were cited under chapter 1200-8-6, Standards for Nursing Homes.	N 000	This page intentionally left blank		

Division of Health Care Facilities

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

STATE FORM

5399

XL5611

If continuation sheet 1 of 1